by battering physicians simply because they fail to save us from our philosophical impasse. On this course we shall only lay waste to the medical profession and kill the soul that once gave it compassion and altruism.

But, alas, we will not treat the disease. It is too easy to look for scapegoats. We will not have the courage to be strong, because weakness is easier. We will not take up the yoke of responsibility because irresponsibility is easier. We will not have true leaders because they must be willing to say what is unpopular. Rather, we will delude ourselves that the shiny trappings of our technology shall make up for our withered soul. We shall go on to slow suicide, afraid to raise our collective philosophy to meet the challenges of technocracy.

And the world will look elsewhere for its 21st century leader. America has had her day. What Dr Johnston wants from physicians, and what we once had to offer, was the product of a different social environment. Requiem.

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REFERENCE

1. Johnston DG: Death of a doctor. West J Med 1994; 160:180

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Dr Johnston Responds

TO THE EDITOR: I appreciate Dr Barbuto's comments relative to "Death of a Doctor" and his incisive, articulate review of not only the current deplorable abuse of physicians by our health care system but also the crisis of decline of the ethics, morality, and responsibility of our citizens and our leadership.

I agree with most of his observations and share his distress over the nearly intolerable conditions under which physicians are expected to serve. On the other hand, physicians must not reject their responsibility to provide humane, compassionate care for those accepted into their practices. For a physician to abandon that responsibility to the sick and injured is an affirmation that it is OK to be irresponsible.

When a physician can no longer tolerate the unfair treatment and persecution from the entities so well enumerated by Dr Barbuto and can do nothing to correct those abuses, that physician can leave medicine and do something else, as I have done.

I would add one other adversity for physicians in some areas: hospitals engaged in pressuring physicians to join hospital-owned provider plans—physicians essentially becoming hospital employees. Other hospital activities include using referral lists to pressure physicians to refer patients to hospital-owned outpatient services and discriminatory surgical scheduling favoring surgeon tenants of office buildings owned by hospitals.

Every physician, however he or she may react to adversities of practice, must continue to provide competent and compassionate care to patients.

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Financing Long-term Care

TO THE EDITOR: In the article "Paying for Long-term Care" by Estes and Bodenheimer in the January 1994 issue,[1] I think the authors have misunderstood the essence of financing long-term care. The ultimate result of financing long-term care and not requiring people to "spend down" to obtain this care, as is presently done, is that we are providing an inheritance for their children. I do not think this is in the public's interest. The principal inequity of our present system is, of course, that a spouse is also impoverished by this "spend-down" procedure. That could be more adequately addressed by allowing the spouse to retain a certain amount of assets for the rest of his or her life with the provision that these assets then go to the state and not to an inheritance.

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REFERENCE

1. Estes CL, Bodenheimer T: Paying for long-term care. West J Med 1994; 160:64-69

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Dr Bodenheimer Responds

TO THE EDITOR: We appreciate the excellent point made by Dr Hann. We do not entirely agree with it, however. The spending of tens of thousands of dollars in savings represents a major financial threat to elderly people themselves, not simply to the inheritances of their children. Many retired people supplement their social security or pension incomes with interest and dividends on their life's savings or see those savings as an important form of financial security.

Dr Hann is correct that society has no obligation to ensure that children will receive an inheritance. But there is a randomness to the need for long-term care that allows the children of parents who die suddenly to receive a large inheritance while children of parents who require years of nursing home care receive nothing. Perhaps a fairer system would be that all Americans are insured publicly for long-term care and that a far higher rate of inheritance taxes be imposed to finance public long-term care insurance. Such a system would tend to equalize the amount of money inherited by younger generations while protecting the savings of the elderly.

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Saccharin Revisited

TO THE EDITOR: The letter by Howard H. Frankel, MD, PhD, in the August 1993 issue on the "Resurgence of Saccharin"[1] suggests that Dr Frankel may be unaware of the research on saccharin conducted during the past 15 years and its current regulatory status. Studies of sodium saccharin conducted before 1977 showed that the addition of higher concentrations of this sweetener to the diet of rats was associated with bladder tumors. As a result, saccharin was banned in Canada and a proposal to ban saccharin was put forth by the United States Food and Drug